Sex and Democracy Jeremy Holmes • The Body and its Breakdowns Susie Orbach
Towards the Creation of Disability Psychotherapists Brett Kahr • Dealing with the
Ravages of Childhood Abuse Sandra Bloom • Solving Family Problems Philippa
Pearson • Notes on Stillness from a Dumb Painter Deborah Russell • Two Flew Over
the Cuckoo’s Nest Deborah Marks • Poems Hans W. Cohn • Pilgrim Susan Cowan-
Jenssen • Obituaries • Websites: Refugees and Victims of Torture • Breaking Free From
The Unspoken Addiction John Karter • Super-Mania and the inability to pause for
oxygen Brett Kahr • Book Reviews include: Hysteria • Mad Men and Medusas
E-MAIL FROM AMERICA

The Grief That Dare Not Speak Its Name: Part I
Dealing with the Ravages of Childhood Abuse

SANDRA L. BLOOM

When someone close to us dies, society generally accepts and even expects us to undergo a process of mourning. Physical death presents a tangible and comprehensible loss. Traditionally, mourning is not just an individual rite of passage, but a socially conditioned and approved pathway for recovery from loss enabling us to let go of those who have died, and prepare ourselves for new attachments.

Largely unrecognized is the necessity and value of grieving for other kinds of losses besides those associated with actual death. A common denominator for adult survivors of childhood abuse and neglect are less tangible, but nonetheless significant losses of hope, of innocence, of love and of joy. For adult survivors, the losses that accompany child maltreatment, are cloaked in silence, lost in the shrouds of history, and largely unrecognized. But these “little deaths” linger as unremoved splinters in the survivor’s psyche for decades. In general, the expression of grief for these losses is unaccepted, rejected, denied and stigmatized. Child neglect represents particular challenges for the adult survivor because victims must grieve for things they never had, and thus never had the chance to lose.

The losses that accompany childhood exposure to terror and violence can only be grasped within the context of attachment theory. Bowlby recognized that “grief and mourning occur in infancy whenever the responses mediating attachment behavior are activated and the mother figure continues to be unavailable” (Bowlby, 1960, p.9). He discussed how “the experience of loss of mother in the early years is an antecedent of relevance in the development of personalities prone to depressive and other psychiatric illnesses and that these conditions are best understood as sequelae of pathological mourning” (Bowlby, 1960, p.11). The loss of mother, or one’s primary caretaker, may be through death, injury, or depression. Or the loss may be a loss of the good mother who is replaced by the mother who withholds, withdraws, neglects, abuses, or fails to protect. As far back as 1962, Khan discussed the idea of cumulative trauma, and the impact of protective failures: “cumulative trauma is the result of the breaches in the mother’s role as a protective shield over the whole course of the child’s development, from infancy to adolescence” (Khan, 1963). He went on to discuss how this can leave a person vulnerable to breakdown later in life.

Bowlby (1963) identified four main variants of pathological responses by bereaved adults and other clinicians and researchers have been busily extending his work to show the relationship between disrupted attachment in childhood as a result of maltreatment, the experience of loss, and the development of adult pathology, especially depression (de Zulueta, 1994). The first variant he described as anxiety and depression, which he saw as the persistent and unconscious yearning to recover the lost person, originally adaptive because it produced strong motivation for reunion. There is a long-established connection between childhood loss and depression (Bowlby, 1980). Adam has recently reviewed the strong connection between suicidal behavior in adolescents and adults and disrupted attachment (Adam, 1994). There is also a growing body of literature connecting childhood maltreatment with a wide variety of physical, psychological, and social dysfunction in childhood and in adulthood and there is now a significant body of literature reviewing various aspects of comorbidity (Ellason et al, 1998; Grady, 1997; Koss, Koss & Woodruff, 1991; Leserman et al., 1996; Salmon & Calderbank, 1996; van der Kolk, 1996). Additionally, there are well-established connections between chronic depressive disorders, somatization disorder, anxiety disorders, and various personality disorders especially borderline personality disorder and childhood exposure to overwhelming and traumatic events (Kessler et al, 1995; Solomon & Davidson, 1997).

Bowlby’s second variant was that of intense and persistent anger and reproach expressed towards others or the self and originally intended to achieve reunion with the lost relationship and discourage further separation; In the last decades, investigators have concretized the relationship between insecure forms of attachment in childhood and the evolution of personality disorders (West and Keller, 1994). Fonagy
and colleagues have helped illuminate the important relationship between disrupted attachment and borderline states (1998).

In his third variant, Bowlby looked at the absorption in caring for someone else who has also been bereaved, sometimes amounting to a compulsion. Linkages may be made between this incomplete form of grieving and dysfunctional, even violent relationships. Investigators have looked at both highly conflicted families and violent couples from the point of view of disrupted childhood attachment relationships (Henry & Holmes, 1998; Roberts & Noller, 1998), while Main & Hesse (1990) and Solomon & George (1999) have provided abundant theoretical and evidence-based data showing how the disrupted childhood attachment relationships of parents can be carried over into the ways in which they parent their own children.

Bowlby’s fourth variant focused on a denial that the relationship is permanently lost, a denial that could link attachment, grieving and the spectrum of dissociative disorders and other difficulties in letting go of abusive attachments and living in the present, not the past (Bowlby, 1963). Recently, Liotti has written about the development of dissociative disorders within an attachment framework (1995, 1999).

Still, when it comes to actually treating victims of childhood abuse and neglect, only rarely does one diagnostic category fit. The overlapping symptoms and complex clinical picture characteristic of adults who have experienced childhood maltreatment is more comprehensible if we formulate the problem as one of “complex post-traumatic stress disorder” (Herman, 1992; Van der Kolk et al., 1994). Field trials for DSM-IV (American Psychiatric Association, 1994), demonstrated that there are significant differences between survivors of disasters who suffer from post-traumatic stress disorder and childhood survivors of maltreatment. These differences fall into seven major categories of dysfunction: alterations in regulating affective arousal, alterations in attention and consciousness, somatization, alterations in self-perception, alterations in perception of the perpetrator, alterations in relationships to others, and alterations in systems of meaning. These symptom clusters have been demonstrated to differentiate acute adult onset trauma syndromes associated with disaster victims from adult victims of childhood interpersonal violence and abuse (Van der Kolk et al, 1994).

When viewed from the point of view of the grief literature, difficulties with managing affect and alterations in attention and consciousness may reflect two of the final adult personality outcomes for two of Bowlby’s sequela of pathological mourning. The unrelenting yearning and searching for the lost love relationship, and the defenses built up to protect against this yearning can be seen as an underpinning for many of the symptoms that lead people to seek treatment. The persistent anger and reproach originally intended to achieve reunion and discourage more separation are common problems for victims of abuse in all of their relationships and strongly color the nature of the therapeutic alliance. It is quite common for survivors of child abuse to be labeled with borderline symptoms, so typically characterized by alternating yearning and anger.

Alterations in self-perception, in perception of the perpetrator and in relationships with others all can be understood in the context of an expectable developmental outcome in the face of disrupted early attachments. Trauma-bonding is a relationship that is based on terror and the twisting and manipulation of normal attachment behavior in service of someone else’s malevolent intent. Successful grieving means letting go of these patterns as well as letting go of the former abusive relationships, even though these relationships are also associated with a deep sense of fear and foreboding at their loss.

Somatization may represent not only the effects of prolonged stress but also the long-term effects of suppressed grief on the body. There is now a large and growing body of literature on the comorbid conditions associated with child maltreatment. Disrupted systems of meaning can be understood as the logical outgrowth of growing up within intimate childhood contexts of mistrust, deceit, hypocrisy and cruelty, that are embedded within a larger social context that insists that children are to be valued, loved, cherished and protected from harm. A child’s exposure to deliberate malevolence at the hands of a primary caretaker powerfully confuses the ability of the child to correlate his or her own experience of reality with the realities of other people. The contradictions are often shattering.

While attachment theorists have been carefully formulating theory and analyzing data from the perspective of developmental psychopathology (Cicchetti & Lynch, 1995), clinicians and researchers in the overlapping fields of traumatic stress studies and thanatology have been broadening our understanding of what happens to people who are traumatized and the ways in which traumatic bereavement differs from normal bereavement. Jacobs has described traumatic grief in relation to any death that is personally devastating and is characterized by traumatic separation. Traumatic grief has been shown to be associated with impaired role performance, functional impairment, subjective sleep disturbance, low self-esteem, depression and anxiety, as well as a high risk of cancer, cardiac disorders, alcohol and tobacco consumption, and suicidal ideation (Jacobs, 1999).

Other authors have looked at the various ways that traumatic bereavement and exposure to death and dying affect various populations and age groups (Figley, 1997; Figley, Bride & Mazza, 1999), while still others have looked at the way entire communities grieve after mass tragic events (Zinner & Williams, 1999).

Rando (1993) has written extensively about the treatment of complicated mourning and has connected unresolved grief to many of the symptoms of chronic and complex post-traumatic stress disorder. She has also looked at the difficulties survivors encounter in mourning someone who has victimized them, as is so often the case in survivors of childhood maltreatment.
At least since Lindemann’s seminal work (1944), the connection between the normal somatic manifestations of grief and symptoms of complicated mourning have been recognized (Engel, 1961; Rando, 1993).

Nonetheless, although the literature is by now rich and persuasive in conceptualizing the relationship between traumatic loss and disrupted attachment, relatively little has been detailed about the losses the do not involve actual death, but that do represent extraordinary loss for adults who were maltreated as children. We do not have adequate language to express the sense of pervasive, repetitive, corrosive, even normative violence experienced by maltreated children other than to use the word “traumatic”. Repetitive losses occur in the context of a long-standing pattern characterized by the absence of sustaining and loving caregiver behavior. As children, our patients often had parents who were physically present, but the nature of their parenting was so abusive and/or neglectful that their losses are not even seen as losses at all, but a way of life.

Over the course of the next two months we will look at the grief that accompanies childhood abuse and neglect more closely. The next column will focus more specifically on the losses that adult survivors must work through in the process of recovery and subsequently, we will look at the process of recovery from these kinds of losses.

References


Dr. Sandra L. Bloom is Executive Director of the Sanctuary Programs at Horsham Clinic, Ambler PA and Hampton Behavioral Health Center, Rancocas, NJ. She is Associate Medical Director of Horsham Clinic.